MINUTES
STATE AID TASK FORCE
(a subcommittee of State Board of Health)
March 17, 2006

Rick Reich, Chairperson, opened the meeting videoconferenced from Las Vegas, Reno and Carson City, at 10: 20 a.m. Roll call taken and determined a quorum was present.

Attending from Carson City:
Amy Roukie, MBA, ASO, Chief Financial Officer
Bradford Lee, M.D., State Health Officer
Chris Lovass-Nagy, LASW, Communicable Disease Program Manager
Lyell Collins, HIV Prevention Coordinator
Cherrill Cristman, MBA, Ryan White Title II Coordinator
Dave Crockett, Surveillance Coordinator
Ihsan Issam, State Epidemiologist
Miguel Forero, Department of Corrections
Jonathan Andrews, Chief Deputy Attorney General, Office of Attorney General
Fran McClain, Recording Secretary

Attending from Reno:

Larry Mastropierro	Jennifer Stoll-Hadayia	James Norwood, M.D.
Jennifer Howell	Larry Pinson	Debra Barone

Attending from Las Vegas:

Rick Reich, Chair	Antioco Carrillo	Susan Little
David Parks	Chris Reynolds	Gary Schroeder, M.D.
Jeannie Pearce	Mary Ellen Harrell	Julie McCain
Melva Thompson-Robinson	Bonnie Sorenson	

Alternates:
Mary Ellen Harrell for Donald Kwalick, M.D.
Jennifer Stoll-Hadayia for Mary Anderson, M.D.
Julie McCain for Marcie Jackson
Melva Thompson-Robinson, M.D., for Mary Guinan, M.D.
Miguel Forero for Dr. D'Amico, recently retired

Those not attending:

Forrest Dunaetz	Dr. Trudy Larson	Nedy Tollerstad
Robert Washburn	Maria Canfield	Rita Boyd
Ben Felix	Kelvin Atkinson	Penny Jackson
Lillian McMorris	Sherman Rutledge	Natalie Silva (notified not feeling well)

Frances Sponer (notified would be in San Diego)
Maurice Washington (newly appointed by LCB)
Robinette Bacon (notified she had another meeting in Las Vegas)

Discussion took place about changing the order of the agenda. Some members wanted the ADAP item before Bylaws, following approval of the three sets of Minutes. Rick Reich, used his power as Chair to change the order to Minutes, followed by item 6, the Bylaws; then item 5, ADAP, and then to item 11, the Updated Statewide Consolidated Statement of Need report.

Agenda item #2: *Approval of May 27, 2004 Minutes.
Motion to approve made by David Parks, seconded by Chris Reynolds and unanimously approved.

Agenda item #3: *Approval of July 21, 2004 Minutes.
Motion to approve made by Chris Reynolds, seconded by Chris Lovass-Nagy, and unanimously approved.

Agenda item #4: *Approval of August 9, 2005 Minutes.
Motion to approve made by Larry Mastropierro, seconded by Chris Reynolds, and unanimously approved.

Agenda item #6, moved to 5th position: *Review and approval of proposed changes to the bylaws.
Rick Reich reported that there are eight major sections to the bylaws, read the sections and subsections and noted any minor changes. The main changes will be to Sections IV and V, Voting and Ex-officio Members. He stated the rationale for change is the lack of quorum at the meetings; too many are required to conduct business. Some members favored change, others suggested equal north/south representation. Talk ensued about why Ex-officio were not also voting. Rick answered numerous questions about the suggestions put forth. Dr. Thompson-Robinson indicated it didn't matter if there were two or 50 if members did not attend. What is needed is people with a feeling for the positions. Cherrill Cristman was concerned about removing Corrections since they work with inmates statewide. Miguel Forero agreed they are located throughout the state and Corrections deal with HIV and STDs. In response to Miguel's statement, Rick indicated that if Corrections feels it represents a highly impacted population, he could apply to be a voting member.

Jennifer Stoll-Hadayia indicated that the Prevention Plan could be used as a basis for selecting applications for the voting membership in the positions listed below. Others agreed they don't want it a north/south issue, but statewide representation. After final discussions, review of the current bylaws and suggestions, members approved changing the voting membership to consist of:

- Three members representing the fields of physicians, nursing, pharmacy, dentistry, counseling and/or health care facilities.

- Two representatives from public health.

- Three members representing one of the highly impacted groups, and/or agencies serving them.

- Two persons with HIV/AIDS.

- Two representatives from the business community/public.

- Two representatives from county coalitions/planning bodies.

Voting members were reduced to 14.

A separate category for a member from Department of Corrections was merged into the three representing highly impacted groups. Also, the legislative member was moved from voting to ex-officio.

Motion made by Antioco Carrillo, seconded by David Parks and unanimously passed to approve the new voting member structure.

A review of the ex-officio members listed in the suggested changes resulted in a decision to add to the 12 in the proposed suggested list, as follows:

- Department of Mental Health and Developmental Services, (moved from voting member),
- A representative from the news media,
- The State Legislator (moved from the voting section),
- State Department of Corrections, (moved from voting member listing), and
- A research academic from the HIV community.

Motion was made by Chris Reynolds, seconded by Larry Mastropierro and unanimously approved.

Rick Reich did another review of minor word changes to clean up the bylaw language and acknowledged that the State Plan and/or the Epi Profile should be used in determining application selection of task force representation. **Motion** made by Larry Mastropierro, seconded by Chris Reynolds, and unanimously approved.

Agenda item #5: *ADAP cost containment strategies, statewide.
Chris Lovass-Nagy presented the report on how the state approached the Interim Finance Committee on January 26th and was given a loan of $1,046,759 to extend the program from fiscal year 2007 ADAP monies. They were also instructed to explore cost saving strategies. They met as a statewide group on February 28. At that meeting the group came up with five strategies to present at the IFC April 4 meeting. The five strategies that the committee selected, are as follows:

1) Implement a waiting list for ADAP effective July 1, 2006, which is beginning of the state fiscal year 2007. This would be most immediate in terms of cost savings, but less preferable. Options 2 through 5 were rated much more palatable to the group, but have less immediate cost savings effect.

2) Investigate reducing income limit for enrollment in ADAP from current 400% of poverty level to 200% of poverty level. This would affect approximately 91 clients.

3) Examine definition of assets and household; to see if the ADAP eligibility rules could be tightened up and we could be sure that those receiving services were actually eligible. It was suggested that Medicaid or Title I Social Service eligibility be used as a model.

4) Develop a plan for implementation of sliding scale fees or co-pays and evaluate the cost savings associated with that. This was actually the first choice of the February 28th group.

5) Move forward with transitioning as many ADAP clients as possible to Medicare Part D coverage as quickly as possible. This is an ongoing process.

When asked who participated in the February 28th meeting, the committee was told that the meeting was held in Las Vegas and was attended by our staff from State Health Division, administration from UMC, HOPES, Clark County Health District, Clark County Social Services, and Washoe County District Health Department. The meeting was open to the public, but this was not a meeting of a public body, it was primarily a meeting for those with ADAP clients. Amy Roukie clarified that they were asked by IFC to prepare a statement for the next IFC meeting covering cost containment measures that could be utilized if needed since they borrowed more than a million dollars for medications from the next state fiscal year. The IFC committee asked the State to assemble a group of stakeholders to put together strategies then come to the State AIDS Task Force for input of what strategies to put forth. Our response will be to the money committee who will assist us along the way in defining fiscal resources to continue to support this program.

Rick Reich asked that the five strategies be repeated again, and Chris Lovass-Nagy re-read the list.

Dr. Schroeder stated that the transition to Medicare Part D is happening now and will take approximately 20% of clients off ADAP which really should improve things dramatically and quickly. Dr. Schroeder felt that the sliding scale won't save much. Ryan White co-pay is in place now, and tightening the household definition is a very good one. All programs across the country are tightening their programs and getting more specific. Reducing to 200% poverty level could be a problem. Someone with $33,000 is at 400% of poverty level, and when medications are $15,000-$20,000 a year reducing them to 200%, $25,000 is ludicrous. Actually those people that are working without insurance fall through the cracks, where everyone else seems to get care. Dr. Schroeder further stated the need to look at all populations: who is sick/not sick, citizen/not citizen, who has money/who doesn't, is unfortunately a waiting list.

Chris Lovass-Nagy said that capping enrollment, which has the same affect as a waiting list, was the most popular cost saving strategy and is used across the country in several states. There are some states with similar profiles as Nevada.

Public comment on ADAP:
No comments from Washoe County.

Bertha Warrick from Clark County indicated that dropping from 400% to 200% is being looked at nationally; very few states are at 400%.

Chris Lovass-Nagy was asked about the 91 clients receiving services and she indicated it was based on the active level caseload of 735 clients, so it was over 10%, about 16%.

Bruce Parrott, co-chair of Ryan White Title I, asked about time frame for waiting list idea – how long. Chris replied it was that it could be first on, first off, or based on CD4 counts, and that there were a lot of options. Chris indicated if we are looking at this as a cost savings, we would have to look at the 735 current cases, for cases to go down which could take six months to a year. The case loads aren't going down, they are increasing about 9%; they are adding about 24 new clients per month. When asked about estimate of savings was told that it was not yet put together. Implementing a waiting list has immediate results. Implementing change in eligibility raises the issue of whether we grandfather people in as in the past. There may be other options such as health insurance continuation or private insurance. Fee scales and co-pays could possibly provide immediate results, but would have to be negotiated with providers and folks at this table. Maybe a $5 co-pay is reasonable. We have to look at big picture but at the same time realize savings. We hope that Medicare is going to save us money but it is not going to happen now. As we transition, we may see some savings by May or June.

Rick Reich asked if anyone had an update on Part D, in terms of how fast it will hit. They still are transitioning people off slowly. Medicare has asked to keep people on ADAP during the transition period. Plans and formulary of plans have much more latitude than clients do. Looking to the plan that is best, they can be changed putting people back on ADAP. Rick asked about level funding. Chris said they have heard it will be level funding, with possibly a cut in the base. In the past the Legislature usually gave us $1.3 million and last year there was a slight increase to $1.6 million, with $1.8 million in the second year of the biennium, less the state money of $1,046,759 borrowed, so we will have less state dollars beginning July 1.

Antioco Carrillo said he had concerns about the clients and how could they pick one of the strategies, keeping in mind the health of clients. Chris indicated they are not asking the task force to pick one, but to concur with the strategies they will present to IFC. The well-being and health of clients is foremost in their minds when looking at this. Dr Norwood added that Dr. Cade and he agreed the least palatable thing is the waiting list. HOPES has just about one-third the clients of southern Nevada but brought in 100 cases last year. With flat funding and a waiting list we could probably guarantee that 60 of those patients within a year would not get medication. An example given was of a young patient who contracted HIV and didn't know he had it until he was near run to death. A wait of 30 or 45 days may have killed him. When you think of a waiting list and administering equitably it is almost impossible not to kill somebody with a waiting list. They think it is the least palatable solution. From their viewpoint they have a lot of patients who are better off than they appear to be. They see some indigents raising it. At HOPES they think one of the most palatable and efficacious is to rearrange the criteria for eligibility for patients, and doing that and Part D could wipe out most of the future debit if not the existing deficit, and reducing the poverty level from 400% to 200% is relatively easy and more efficacious. All we favor would require more time, and the legislature allowing more time and coming up with more money. Getting the legislature to allocate more money in the short term , in the long term it would reduce costs, but alleviate the waiting list.

Amy Roukie stated that it is the states responsibility to approach the next IFC with an informational item of what we discovered. We won't go before them until either late summer or

early fall to take a look at our financial status and what cost containment measures they have suggested we implement, including the Medicare Part D portion, and assess our financial status at that point and request more general funds for these activities. If they at IFC want a waiting list the Health Division would have to come back to this committee. It supports our coming back to IFC next year and asking for more money.

Rick expanded the information to say they started with sixteen items that they then reduced to the five presented. These were ones that the February 28th group was the most comfortable to work with and to put in a document to IFC. Any Roukie said they will be presenting a formal report from the January meeting. That report addresses their request for us to meet with community groups to discuss this issue. We will report that the January and the February meetings did occur and these groups have indicated that, of those options presented, these would be the most palatable. We are just putting the information out to everyone and our hope is that Medicare Part D will reduce our costs and keep us going along. IFC has not asked to implement any of these strategies yet, but anticipate after providing the report they could. They will have the information at the committee level to decide if they are palatable to them. We hope that Medicare Part D will be successful so that we do not have to put these strategies in place. She added there is good work to be done, but hope they will say 'good, proceed as you are doing, work on Part D and come back later'.

Question was asked if IFC asked for immediate savings, how would that be addressed? Amy responded if they want immediate savings the only plausible activity is a waiting list. Those activities would have to come back to a committee like this to determine what works. After the 4/4/06 IFC meeting the Health Division will have the opportunity to get back to stakeholders

Agenda item #11 (as moved up on the agenda) Updated Statewide Coordinated Statement of Need report from the meeting October 10, 2005 and the priorities discussed and open forum.

Cherrill Cristman explained the process for the SCSN meetings. There were two meetings, first October 2004 and the other October 2005. Priorities for care were discussed and rated. ADAP and Primary Care were chosen as #1 and Case Management in second slot. With HRSA funding cuts and the greatly increasing cost of ADAP, a huge need is cost savings. When putting together the short and long term goals for the Care Plan for the next three years everything is geared to cost savings or funding services, funded by other means than Ryan White money. HRSA is to provide technical assistance for ADAP cost savings; they will be looking at various interventions that many states are using, including the feasibility of a Risk Pool for insurance. We hope to have all completed by June so that the information can be provided to Health Division Administration, and perhaps carried forward to the Legislature in the coming session. Another goal is researching every available health insurance policy that has pharmacy coverage that would be applicable to clients for enrollment, to shift cost burden from Nevada ADAP to private sector insurance companies.

We are going to have statewide quarterly meetings with providers to share information about private insurance and track client enrollment. Cherrill will be presenting an update on the ADAP expenditure status with the Northern Nevada Planning Council and Title I Resource and Allocation Committee meetings. Case Managers will be asked to assist identifying service providers not funded by Ryan White that can supplant the Ryan White funded services to any

degree possible. CBOs are encouraged to write grants. Anyone wanting an electronic copy of the Care Plan was told to contact the State.

Cherrill then opened this item to questions.

Antioco questioned who was involved in this process, Cherrill responded that the state convened the meetings and worked in collaboration with Rick Reich. Rick said to clarify with the task force, and he happens to be the chair.

Public comment ensued:

Bruce Parrott asked how the Titles were involved in the SCSN. He feels Clark County is seeing the majority of the epidemic. Cherrill responded that participants were invited in accordance with HRSA requirements for representation.

Bertha Warrick commented that she needed clarification of the priority level. She said that both Washoe and Clark at the SCSN meeting had selected Case Management as first. Their constituents felt that Case Management was most important. They realized that the north had ADAP, but she wanted to stress that Washoe and Clark felt Case Management was first.

Cherrill replied she understood Case Management was a very important issue but said they did reach a consensus at the end, with Primary Care and ADAP in the first place and Case Management in second place. Jennifer Stoll-Hadayia responded that she was in the north and they were in agreement with Clark County that Case Management was a very high priority.

Antioco, indicated at the Title I program, they were not wrong, this was their job. Jennifer added she doesn't think this is a north/south thing, believes all were in agreement about Case Management. Question about how presented. Cherrill said the decision was that Primary Care and ADAP was #1 and Case Management was #2

Discussion opened:
Asked if the SCSN was on the Internet, Cherrill stated that there is a process to what goes on the Internet; the SCSN is not yet on the Internet. Jennifer indicated they could put in on their Internet in Washoe County. Asked about how the document was created, Cherrill stated that it was reviewed by the Title II Planning Council, which provided a Letter of Concurrence. Title I in the south reviewed the document and provided a Letter of Concurrence. Rick Reich also provided a Letter of Concurrence.

Cherrill added this is a living document, which can be amended as appropriate. While HRSA requires that Title I and II use the document for guidance, they can vary from the document as long as they provide a justification. As we go along, our goals and objectives may shift and change in the next three years. So it's a Plan, it's a Statement of Need.

Rick Reich stated two meetings took place and asked what future plans the Health Division has as grantee for Title II, and any planned changes or updates and time line for that. Cherrill responded that Rick and she have talked about this and about who should attend and when we will have meetings, and she feels she has worked in collaboration with the Rick as Task Force

chair. She's open to suggestions from the task force and Rick as to how he would like to move forward with the SCSN and Care Plan. Rick indicated he won't be the chair and Cherrill indicated that she would work with whoever is chair. Rick indicated that he had thought that the process would be much more extensive, more public participation in multiple meetings. Cherrill indicated no such plan was offered to her. She added she did what was expected, following the government guidelines.

Jennifer stated the meetings need to be more open to the public, getting all feedback from all peoples. Next meeting should be more public, though not under the open meeting law.

Suggestion made to move on. Rick then referenced the next agenda item #7. Noting people were leaving, Jonathan Andrews, the Deputy Attorney General, indicated need to see if a quorum still existed. Chris Lovass-Nagy had given her proxy to Dave Crockett, Mary Ellen gave Dr. Kwalick's proxy to Bonnie Sorenson when she left, Dr. Schroeder left and Miguel Forero left. A quorum was lost and there could no longer be a meeting.

It was mentioned that the bylaws changed the membership so a question on how to vote a chair came up. Jonathan Andrews, Deputy Attorney General, said until the Board of Health approves the new membership, the old membership continues.

Meeting ended at 1:35 p.m. with the remaining agenda items not heard.